FLORIDA HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 839	**COMPANION BILL:** CS/SB 944 (Davis)
TITLE: Insurance Overpayment Claims Submitted to Psychologists	**LINKED BILLS:** None
SPONSOR(S): Booth	**RELATED BILLS:** None

FINAL HOUSE FLOOR ACTION: 115 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Pending

SUMMARY

Effect of the Bill:

By default, under Florida law, health insurers and health maintenance organizations (HMOs) have 30 months after rendering payment to a healthcare provider to submit a claim for overpayment. The bill reduces the 30-month period to 12 months for overpayment claims submitted to licensed psychologists for services provided on or after January 1, 2026.

The bill adds licensed psychologists to a list of healthcare providers that already enjoy the 12-month overpayment claim window under Florida law, including chiropractors, podiatrists, osteopaths, certain physicians and dental surgeons.

Fiscal or Economic Impact:

Insurers and HMOs may recover less from overpaid claims to psychologists due to the reduced overpayment claim period. The effect on premiums is indeterminate.

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ANALYSIS

EFFECT OF THE BILL:

Psychologist Overpayment Claims

CS/HB 839 passed as CS/SB 944.

The bill adds psychologists licensed under ch. 490, F.S., to a list of licensed providers that enjoy a reduced time period for insurers and health maintenance organizations (HMOs) to submit claims for overpayment. Under the reduced time period, claims for overpayment must be submitted to the provider within 12 months, rather than the standard 30-month period.

The changes in the bill apply to claims for services provided on or after January 1, 2026.

Subject to the Governor's veto powers, the effective date of this bill is July 1, 2025.

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

Insurers and HMOs may recover less from overpaid claims to psychologists due to the reduced overpayment claim period. The effect on premiums is indeterminate.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Care Service Claims Overpayments

An overpayment is an insurance reimbursement for provider services in an amount that is more than is required by the contract between the payer and the provider. Overpayments might take the following forms:

- **Duplicate Payments** – Patients or their family members may inadvertently make multiple payments for the same service.[1]
- **Billing or Coding Errors** – Mistakes in billing codes or modifiers can occur and lead to inaccurate charges on a patient's account.[2]
- **Excess Patient Responsibility Collected** – A patient's insurance benefits or deductibles may be miscalculated by either the patient or the health care practitioner.[3]
- **Coordination of Benefits Between Multiple Insurers** – Patients sometimes have two or more sources of insurance coverage (primary and secondary insurance plans). If both insurers remit payment and inadvertently exceed the cost of the service, the health care practitioner may receive funds beyond what is contractually required.[4]

Oftentimes, overpayment claims are the result of a retroactive review or audit of coverage decisions and payment levels.

Subsections s. 627.6131(6), F.S., and 641.3155(5), F.S., govern the process by which a health insurer or health maintenance organization (HMO), respectively, may make a claim for overpayment against a provider to whom it rendered payment. The insurer or HMO must send a written or electronic statement specifying the basis for the retroactive denial or payment adjustment to the provider of the specific claim(s) for which the overpayment is submitted.

If the overpayment is not related to fraud, the health insurer or HMO must submit its claim for overpayment within 30 months after the insurer or HMO paid the claim. After receiving the claim for overpayment, the provider has 40 days in which to pay, deny, or contest the claim. A contested claim for overpayment must be paid or denied by the provider within 120 days after receipt. If, after 140 days, the provider has not paid or denied the overpayment claim, an uncontestable obligation is placed on the provider to pay the insurer or HMO claim. A provider that chooses to deny or contest an insurer or HMO claim must notify the insurer or HMO in writing of the provider's decision within 35 days after the provider received the claim for overpayment. If the claim is contested, the provider must request additional information, which the insurer or HMO must give the provider within 35 days after receiving the request. After receiving the additional information, the provider has 45 days to pay or deny the claim.

Subsections s. 627.6131(18), F.S., and s. 641.3155(16), F.S., establish a different time period for overpayment claims for certain providers. Claims for overpayment must be submitted within 12 months, rather than the usual 30-month period for physicians licensed under ch. 458, F.S., osteopaths licensed under ch. 459, F.S., chiropractors licensed under ch. 460, F.S., podiatrists licensed under ch. 461, F.S., and (for oral surgery only) dental surgeons licensed under ch. 466, F.S.

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[1] Azad, T. and William, P., *Fraud Detection in Healthcare Billing and Claims*, International Journal of Science and Research April 2025 (Vol 15, Issue 1), available at https://ijsra.net/content/fraud-detection-healthcare-billing-and-claims (last visited, April 8, 2025).
[2] *Id.*
[3] PBS News, *Health Insurance Claim Denials are on the Rise, to the Detriment of Patients*, available at https://www.pbs.org/newshour/health/analysis-health-insurance-claim-denials-are-on-the-rise-to-the-detriment-of-patients (last visited, April 8, 2025).
[4] Nupur Gambir, *Coordination of Benefits: How Having Two Health Insurance Plans Works*, (March 11, 2025) available at https://www.insure.com/health-insurance/how-coordination-of-benefits-works/ (last visited, April 8, 2025).